Note: Due to technical difficulties with the recording of this meeting, the minutes may not reflect all remarks and comments made during the meeting.

Financial Solvency Standard Board Meeting
April 10, 2019
Meeting Minutes

Financial Solvency Standards Board (FSSB) Members in Attendance:
Jeffrey Conklin, Adventist Health Plan
Paul Durr, Sharp HealthCare
Jen Flory, Western Center on Law and Poverty
John Grgurina, Jr., San Francisco Health Plan
Dr. Jeff Rideout, Integrated Healthcare Association
Shelley Rouillard, Department of Managed Health Care

Department of Managed Health Care (DMHC) Staff Present:
Pritika Dutt, Deputy Director, Office of Financial Review
Sarah Ream, Acting General Counsel
Wayne Thomas, Chief Life Actuary, Office of Financial Review
Mary Watanabe, Deputy Director, Health Policy and Stakeholder Relations
Michelle Yamanaka, Supervising Examiner, Office of Financial Review

Chairperson John Grgurina called the meeting to order and asked Shelley Rouillard to introduce Jen Flory as the new board member. Ms. Rouillard stated Ms. Flory is currently an attorney and policy advocate at the Western Center on Law and Poverty, and provided a brief overview of her biography.

Minutes from January 30, 2019 FSSB Meeting

Mr. Grgurina asked if there were any changes to the January 30, 2019, FSSB meeting minutes. The meeting minutes were approved with no changes.

Director's Remarks

Ms. Rouillard provided an update on several personnel changes at the DMHC. Mary Watanabe will be Acting Chief Deputy Director, while Marta Green is on leave. Deborah Haddad, an attorney in the Office of Plan Monitoring, will be Acting Deputy Director of Health Policy and Stakeholder Relations. Sarah Ream is continuing to serve as the Acting General Counsel while Gabriel Ravel is working at the California Health and Human Services Agency (CHHS).

Ms. Rouillard announced the appointment of Dr. Mark Ghaly as CHHS Agency Secretary, and provided some background information on him. Dr. Ghaly is also a

practicing pediatrician. Ms. Rouillard stated she looks forward to working with him to accomplish the DMHC's mission.

Ms. Rouillard said the Department has four Budget Change Proposals (BCPs), currently being considered in the legislature.

- Division of Plan Surveys Workload. The BCP is for four positions and $2.1 million for consulting services to address the increases in the number of health plans and in the market rate for consultants.
- Health Plan Mergers and Acquisitions. Assembly Bill (AB) 595 provided the Department with the authority to disapprove health plan mergers if it violates the Knox-Keene Act (KKA) and reduces competition. The BCP is for $1.33 million dollars for consulting services to assess the impact of these transactions and to hold public meetings.
- Health Plan Disciplinary Actions (AB 2674). AB 2674 established mandates for the Department to annually review complaints submitted by health care providers, to determine if a plan is in violation of the KKA. The BCP is for nine positions and $2.1 million, and includes replacing the database for the Provider Complaint Unit.
- Pharmacy Benefit Management Reporting (AB 315). AB 315 requires pharmacy benefit managers (PBMs) to register with the Department and creates a Task Force to evaluate what type of data health plans or their contracted PBMs should be reporting to the Department. The BCP is for two positions and $2.2 million for implementation of AB 315.

Ms. Rouillard provided an overview of the General Licensure Regulation. The Office of Administrative Law (OAL) approved the General Licensure Regulation on March 5, 2019, and it will go into effect July 1, 2019.

The purpose of the regulation is to ensure consumers have the full and meaningful protections of the KKA, ensure entities arranging or delivering health care services have the financial means to provide a stable health care delivery system, and to codify the DMHC's practice of licensing restricted health plans.

The regulation requires entities that accept global risk to get either a license or an exemption from the DMHC. Unlicensed entities are taking on significant financial risk with limited or no oversight. This raises concerns that these entities may not have the financial or operational capacity to manage the risk, and may be financially motivated to delay or deny necessary care.

The regulation applies to contracts entered into or renewed or amended after July 1, 2019. The entity accepting global risk will need to request an exemption or get a license. The Department is working on guidance for entities to use for requesting exemptions. An entity with questions about the regulation should contact the Department through the **DMHC stakeholder relations email**.

Note: Due to technical difficulties with the recording of this meeting, the minutes may not reflect all remarks and comments made during the meeting.

Ms. Rouillard provided an overview of three other regulations:

- Financial Solvency of Risk Bearing Organizations (RBO) establishes more stringent financial requirements for RBOs. It was submitted to OAL for approval and OAL has until early May to approve. If approved, the regulation would go into effect July 1.
- Standard Prescription Drug Formulary Template. The Department is reviewing comments and the regulation will be sent over to OAL at the end of April.
- Cancellations, Rescissions and Nonrenewals. The second 15-day comment period closed. The DMHC expects to submit the final package to OAL in the next couple of months.

Ms. Rouillard provided additional information on the Department's implementation of AB 315. The Department is required to convene the Task Force on Pharmacy Benefit Management Reporting by July 1, 2019. The Task Force will make recommendations to the DMHC on what pharmacy information the Department should require health plans or their PBMs to report. The Department will share these recommendations in a report to the Legislature. The DMHC is soliciting members for the Task Force, which will include nine members plus Ms. Rouillard. Information for those interested in serving on the Task Force can be found on the DMHC website. The Department is seeking individuals with expertise in areas such as health care economics, pharmacy management, prescription drug distribution and actuarial.

Ms. Rouillard also noted a Request for Offer (RFO) was released for a facilitator to moderate the Task Force meetings. The DMHC is planning to hold the first meeting in either June or July.

Ms. Rouillard provided an update on the undertaking related to the Symphony Provider Directory (Symphony). Gaine, the vendor who developed the database, is transitioning approximately 60 provider groups into Symphony. The goal is to have 85 provider groups participating by the end of the year. She also noted the first year of participation in Symphony is subsidized.

Dr. Jeff Rideout stated there are two national plans, Aetna and Cigna, participating, which can be challenging as they have a presence in other states.

Ms. Rouillard shared an update on the Encounter Data Project sponsored by Health Net. Health Net released a Request for Proposal (RFP) for a contractor to facilitate the stakeholder process to address how to achieve more accurate and timely encounter data. Health Net will make a recommendation at the May Advisory Committee meeting. In addition to the stakeholder process, Health Net, Aetna and the Integrated Healthcare Association (IHA) continue to meet to coordinate efforts regarding the undertaking in CVS's acquisition of Aetna, which includes $500,000 directed to encounter data.

Note: Due to technical difficulties with the recording of this meeting, the minutes may not reflect all remarks and comments made during the meeting.

Discussion

Paul Durr asked if it was possible to meet the risk regulation deadline of July 1, 2019 given the amount of new information and a better understanding of the arrangements the Department has received. Ms. Rouillard stated the DMHC is not expecting to get all of it done by July 1, but will be prepared to receive the requests for licensure and exemptions.

Sarah Ream, Acting General Counsel, added the DMHC is working on a phased-in approach for the implementation of the regulation. Under the phased-in approach, for contracts with upside only risk or a bonus payment, the entity would submit their contract along with a request for an exemption. The Department will consider the contract a "file and use" contract and grant an immediate exemption for the term of the contract. This approach is expected to be in place for six months to a year. Additionally, the Department will be issuing guidance to clarify who the regulation applies to.

Dr. Rideout stated Atlas looks at fully capitated, global and dual risk, and may have information that is helpful to the Department. Mr. Durr asked if this information is on the Atlas website. Dr. Rideout responded it was.

Jeffrey Conklin asked if the regulation extends to Management Services Organizations (MSOs). Ms. Ream responded the regulation is not limited to a particular type of entity, but does clarify that any entity assuming global risk, as defined in the regulation, would need to get an exemption or a license.

Mr. Durr asked if the Department is defining the amount of risk. Ms. Ream stated the regulation is silent regarding the amount. Any amount could trigger a filing under the regulation, but the regulation lists considerations for the DMHC Director to look at for exemptions. It would be dependent on the arrangement and the entity itself.

Mr. Conklin asked if an Independent Practice Association (IPA) has risk and pushes that risk down to a lab or imaging center, does the regulation extend down to the lab. Ms. Ream stated it would depend on the arrangement and the risk taken. If risk goes to the lab, the lab is outside of the DMHC's jurisdiction.

Dr. Rideout asked if creating an inventory of these arrangements was a primary or secondary goal of the regulation process. Ms. Ream stated the inventory did not start as a goal, but learning the nature of arrangements is a secondary benefit.

4) Federal Update

Ms. Ream provided an update on two litigation cases and a Request for Information (RFI) from the Centers for Medicare and Medicaid Services (CMS).

Ms. Ream discussed the first case, *Texas v. Azar*, where the Federal District Court in Texas held that the Affordable Care Act (ACA) is unconstitutional. The case is on

appeal with the 5th Circuit Court of Appeal. Ms. Ream provided an overview of arguments and positions of the United States Department of Justice. The Department of Justice urged the Court of Appeal to uphold the lower court's position. Sixteen states, including California and the District of Columbia, are now appealing. The Court of Appeal has not yet set a hearing date for oral arguments, but Ms. Ream noted it likely would be in mid to late September.

Ms. Ream provided an update on *New York v. United States Department of Labor*. The case involves the Trump Administration's Final Rule regarding Association Health Plans (AHP). Eleven states, including California and the District of Columbia, sued to enjoin the final rule, arguing the rule stretches the definition of what is an employer, as defined in the Employee Retirement Income Security Act (ERISA).

Ms. Ream provided an overview of AHPs and explained how they are subject to the ACA's rules regarding individual and small group coverage. When an employer joins an AHP, the product must cover the 10 essential health benefits required in the individual and small group markets. The new rule has done away with the look through provision, allowing the AHP to be considered large group coverage, which means the products purchased by the AHP do not have to cover the 10 essential health benefits. The concern is this will undermine the individual and small group markets as more people will move into the large group market. The Federal District Court in New York found the new rule expanded ERISA's definition of an employer and remanded it back to the Department of Labor. The Department of Labor has until May to appeal.

Ms. Ream mentioned CMS recently issued a RFI asking states to weigh in on insurers selling across state lines. The current law allows interstate insurance sales, but each state needs to agree to it under a compact. In California and some other states, an entity must be licensed within the state to sell health coverage in that state.

Discussion

Dr. Rideout asked if there had been any response from Governor Newsom's letter to the Trump Administration. Ms. Ream was not aware of any response.

Ms. Flory, referring to the New York case, asked if the case goes through, would ERISA preempt state law. Ms. Ream responded that it would depend on how broadly it was crafted.

5) Large Group Aggregate Rates

Pritika Dutt, Deputy Director, Office of Financial Review, provided an update on the large group rate information submitted by the health plans on October 1, 2018, as required by Senate Bill (SB) 546. SB 546 requires health plans with large group products to file aggregate rate information with the DMHC annually. The DMHC is required to annually conduct a public meeting, which was held on March 12, 2019, in San Francisco. Health plans are required to include in their 60-day renewal notices to

employers a comparison of the rate change to rate changes in Covered California and the California Public Employees' Retirement System (CalPERS).

Ms. Dutt reviewed the key findings for the January 1, 2018, through December 31, 2018, reporting period:

- The Covered California 2019 average rate increase was 8.7 percent and CalPERS was 1.1 percent.
- Twenty-four health plans filed large group rate information.
- Nearly 7.8 million enrollees in 13,600 groups were impacted by a rate change in 2018.
- The average unadjusted rate increase was 5.4 percent and the average adjusted rate increase was 5.7 percent. The average monthly premium was $488. The adjusted average premium increase, adjusts for changes in benefits, cost sharing, provider network, geographic rating area and average age.
- Kaiser made up 65 percent of large group enrollment, so the results are displayed with and without Kaiser. Kaiser's premium increase was 4.7 percent. Excluding Kaiser, the overall average increase is 6.6 percent for all other plans.
- Seven statewide plans across all product types represent 97 percent of enrollment in the large group market.
- Of the ten regional plans, Western Health Advantage, Sharp Health Plan, and Sutter make up almost 75 percent of the covered lives. Regional plans represent about 3.3 percent of enrollment in the large group market.
- The majority of employer groups, around 72 percent, and the majority of covered lives, around 88 percent, were enrolled in a Health Maintenance Organization (HMO) and had an average premium of $481.
- Two plans, Anthem Blue Cross and Blue Shield, offered a PPO product, which had the second highest average premium at $602.
- Anthem Blue Cross was the only plan to offer an EPO product and it had the highest average premium at $763. High Deductible Health Plans (HDHP) had the lowest average premium; however, enrollees pay significant out-of-pocket costs.
- Nearly 93 percent of covered lives are in a plan with an actuarial value of at least 80 percent.
- The majority of the plans expect medical trends to decrease slightly in 2019 or remain fairly flat. Projected medical trends are expected to be about 6.6 percent for the statewide plans (excluding Kaiser) and 4.7 percent for the regional plans.
- Pharmacy allowed costs represent 15 to 25 percent of the overall medical allowed costs, and this percentage is steadily rising as prescription drug trends have outpaced medical services in recent years. The increase in pharmacy trend is likely due to the impact of new specialty drugs.

Note: Due to technical difficulties with the recording of this meeting, the minutes may not reflect all remarks and comments made during the meeting.

- Regional plans expected pharmacy trends to increase from an average of 5.5 percent in 2018 to 8.0 percent in 2019, which is lower than the statewide plans.
- Information regarding prescription drug costs must be submitted by plans with large group products as required by SB 17. Prescription drug costs were 11.6 percent of total health care premium. This equates to about $55 Per Member Per Month (PMPM) out of an average premium of $477 PMPM.
- Specialty drugs made up for more than 50 percent of total prescription drug spending for the large group plans.
- The average premium increase was 4.1 percent of which 0.8 percent was attributed to pharmacy cost.

Discussion

Dr. Rideout noted UnitedHealthcare and Aetna exceed the percentage increase for CalPERS and Covered California and wanted to know what the Department does when this happens. Ms. Rouillard responded the Department does not do anything because it is just a reporting requirement.

Mr. Conklin added the medical expenses, admin and net income does not add up, and come up 2 or 3 points short and asked what the fourth item could be. Wayne Thomas, Chief Life Actuary, Office of Financial Review, suggested profit and Ms. Dutt thought taxes and fees may be reported separately.

Mr. Conklin asked if there would be a change in how items are calculated if a PBM is brought in-house. Ms. Dutt responded it would not matter.

Mr. Durr expressed concern from provider groups around the cost of prescription drugs and where the risk lies. Plans continue to push the risk to medical groups and drug costs are not built into the premiums, despite being very expensive. Mr. Durr then asked how this is accounted for and how retail pharmacy is defined. Ms. Dutt explained, for the purposes of SB 17, pharmacy is defined as anything administered, paid for, or filled by a retail or mail order pharmacy. Mr. Durr said there are a lot of missing pieces, and on the horizon are new specialty drugs, which will be a big concern. Ms. Dutt explained the pharmacy costs that are the responsibility of the RBO and part of the capitation payment are not accounted for in the SB 17 report.

Mr. Conklin said a couple of plans are moving high-cost drugs from the medical benefit to the pharmacy benefit. This is concerning because of the out-of-pocket expenses left to the patient.

Mr. Grgurina added one final comment, noting the nice transition from Ms. Ream’s presentation on what is occurring at the federal level and then following with the presentation on large group aggregate rates. It appropriately showed what is going on in Covered California and CalPERS and the reason the rates are so high is because of the federal government and the lack of funding for cost-sharing reductions.

Note: Due to technical difficulties with the recording of this meeting, the minutes may not reflect all remarks and comments made during the meeting.

Bill Barcellona, America's Physician Groups (APG), expressed his appreciation for the report, but noticed the filings are separated as risk bearing and non-risk bearing providers. Mr. Barcelona thought it would be helpful for the Board to evaluate where the risk-based provider trend is in these large group filings compared to non-risk based at an aggregate level.

Yasmin Peled, Health Access California, expressed her appreciation for the SB 546 meeting in San Francisco and the opportunity for individuals to share their comments. Ms. Peled added there are a number of stakeholders, including Health Access, interested in exploring a rate review process in the large group market as a way to address rising health care costs.

6) National Trends in Individual and Small Group Premiums

Brian Stentz, Lewis & Ellis, Inc. presented an overview of how California rates in the individual and small group markets compare to other states. Mr. Stentz noted the following states were included in the analysis for comparison: Colorado, Florida, Maryland, Massachusetts, New York, Oregon, Texas and Washington. All but three of the states have their own exchanges.

Mr. Stentz made the following observations:

- California's average rate increase in the individual market in 2019 was 8.6 percent. Many states had higher rate increases than California due to overcorrecting in prior years.
- California's average rate increase in the small group market was 3 percent compared to an average of 3.9 percent for the other states. The small group market tends to be more stable and it has not been impacted by the ACA changes.
- Compared to other states in the sample, California had some of the highest average rate increases by metal tier.
- California's prescription drug trend for 2019 was 12 percent, a decline from 13.6 percent in 2018.
- California's projected administrative expenses for the individual market were the lowest of the states in the sample. However, the projected administrative expenses for the small group market was second highest.
- California's projected profit margin for the individual market was the third lowest, while the projected profit margin in the small group market was the lowest.

Note: Due to technical difficulties with the recording of this meeting, the minutes may not reflect all remarks and comments made during the meeting.

Discussion

Mr. Grgurina asked if the mean weighted average was calculated based on membership. Mr. Stentz replied the premium is used to calculate the weighted average.

Ms. Flory said she is starting to hear about more people ending up in Health Care Sharing Ministries, which are being marketed like short-term plans. She asked if that could have a significant impact on California rates. Mr. Stentz replied he did not know if it would be significant, but would be something to continue to review.

Dr. Rideout asked for additional information on Maryland's individual market. Mr. Stentz did not have any information, but noted it was small.

Mr. Barcelona stated he is concerned about health plans shifting the burden of risk adjustment transfers down to physician groups and the significant risk exposure for capitated physician groups. Mr. Barcelona asked the Department to look into the issue and render an opinion.

7) Financial Summary of Medi-Cal Managed Care Health Plans

Ms. Dutt discussed the Financial Summary of Medi-Cal Managed Care Plans for the quarter ending December 31, 2018. The report highlights enrollment and financial information for Local Initiatives (LIs), County Organized Health Systems (COHS), and Non-Governmental Medi-Cal Plans (NGMs) with greater than 50 percent Medi-Cal lives.

LIs:

- Nine LIs serve over 5 million Medi-Cal beneficiaries in 13 counties.
- For the second quarter, LIs reported total net income of $91 million.
- The tangible net equity (TNE) to required TNE ranged from 485 percent to 782 percent.

COHS:

- Six COHS plans serve 22 counties.
- Five COHS that report information to the Department serve approximately 1.9 million Medi-Cal beneficiaries.
- For the second quarter, COHS reported total net losses of $27 million.
- TNE to required TNE ranged from 704 percent to 1,118 percent.

NGMs:

- Seven NGM plans serve 3.2 million Medi-Cal beneficiaries in 31 counties.
- For the fourth quarter, NGM plans reported total net income of $169 million.
- TNE to required TNE ranged from 285 percent to 1,441 percent.

Note: Due to technical difficulties with the recording of this meeting, the minutes may not reflect all remarks and comments made during the meeting.

In conclusion, Ms. Dutt said Medi-Cal Managed Care plans continue to meet or significantly exceed the minimum TNE requirement. Overall, premiums, revenue and expenses have stabilized compared to the significant growth during 2014 to 2016. Net income has significantly decreased and a few plans have reported net losses in recent quarters, resulting in decreases in TNE. There are also a few plans projecting net losses for the 2018-19 fiscal year, which would further decrease their TNE.

Discussion

Dr. Rideout questioned why two or three plans had a negative net income and if there was anything to take away from that relative to the other COHS plans. Ms. Dutt said she followed up with the plans and they are investing in their community to strengthen the safety net. Ms. Rouillard echoed that comment stating this was also true for Partnership Health Plan.

Ms. Rouillard asked a similar question related to California Health and Wellness, a for-profit company, on why their reserves seem to be on the lower side. Ms. Dutt replied California Health and Wellness is getting a rate decrease from the Department of Health Care Services (DHCS) and the plan is renegotiating some of their provider contacts.

Ms. Rouillard asked if Centene, their parent company, had put any money into the plan. Ms. Dutt was unsure and would look into that. She noted they do look at how well the publically traded entities are doing and if the plans have access to money.

Mr. Grgurina provided another take on the topic, suggesting that if you look at a large company and break up their experience by areas, one might see that one part is stronger than the other. They may be losing in one section, but are covered by their gains in another area.

Ms. Flory asked why Medi-Call enrollment is going down. Ms. Dutt responded Medi-Cal enrollment overall is going down and the commercial enrollment is going up, which could be because enrollees may now qualify for health care through their employer.

Mr. Durr commented on negative net losses and wondered if plans are investing in social determinants or other projects because the losses are concerning even with reserves.

Ms. Dutt responded the DMHC reviews detailed financial statements and attends board meetings to hear what the plans are doing.

Note: Due to technical difficulties with the recording of this meeting, the minutes may not reflect all remarks and comments made during the meeting.

8) Provider Solvency Quarterly Update

Michelle Yamanaka, Supervising Corporation Examiner, Office of Financial Review, provided an update on the financial solvency of RBOs for the quarter ending December 31, 2018:

- 184 RBOs are required to file financial information with the Department and all RBOs are required to file annual reports. To date, 21 RBOs have filed their annual survey reports for the fiscal years ending March, June and September of 2018. The remaining RBOs will be filing their financial reports for the fiscal year ending December 31, 2018, by May 30, 2019.
- 127 RBOs filed quarterly financial survey reports and 57 RBOs filed compliance statements. 11 RBOs filed monthly financial reports as required by their corrective action plan (CAP).
- 176 of the reporting RBOs reported compliance with the solvency criteria including:
    - 29 RBOs were in the Superior category, of which one RBO was on a CAP.
    - 90 RBOs were in Compliant category, of which eight RBOs were on a CAP and four RBOs were on the monitor-closely list.
    - Eight RBOs reported non-compliance.
- There were 21 RBOs on a CAP. Of those, 14 RBOs improved from the prior quarter and three did not. Additionally, there were four new CAPs in this quarter.
- Of the 21 CAPs, 14 have been approved, five were completed as a result of their December 31, 2018 financial filing review and two have been closed as a result of the RBO ceasing operations.
- There were 88 RBOs with Medi-Cal enrollment covering approximately 3.9 million enrollees.
    - The top 20 RBOs served approximately 3 million Medi-Cal lives. Of these, 15 have no financial concerns, four were on a CAP and one is on the monitor closely list.
    - The remaining 68 RBOs served approximately 1 million Medi-Cal lives. Of those, 56 have no financial concerns, 10 were on a CAP and two were on the monitor-closely list.

Ms. Yamanaka stated the Office of Financial Review has 24 audits planned for 2019, of which 10 are in progress and 14 are planned for the remainder of the year.

Note: Due to technical difficulties with the recording of this meeting, the minutes may not reflect all remarks and comments made during the meeting.

Discussion

Mr. Durr asked if the Department has ordered the closure of medical groups that are becoming insolvent and asked for an explanation of the process for winding down or ceasing operations.

Ms. Yamanaka responded normally the Department works with RBOs and health plans to obtain compliance. If the health plans see concerns, they may move members, which may trigger the winding down of operations.

Ms. Rouillard commented, in some cases, the Department may require the plans to de-delegate to RBOs, if they are financially on the edge. That could result in the RBOs having to wind down because they are no longer getting capitation. However, generally, the Department does not order them to cease operations.

Mr. Durr asked if this also applies to Accountable Care Organization (ACO) arrangements that are taking on risk. Ms. Rouillard responded it would depend on the specific circumstances including what the relationship is between the plan and RBO and its associated risk.

Ms. Rouillard noted Primary Provider Management Company (PPMC), which is a MSO, has a number of RBOs that they are performing claims payment for. They have multiple deficiencies across all of those groups. Since the Department does not have direct control or authority over the MSO, Ms. Rouillard asked if those issues are addressed with the RBO. Ms. Yamanaka replied each RBO is looked at individually because they have their own set of financial statements. For example, groups that are under PPMC have the same parent. In those cases, the Department asks questions regarding the parent to see the overall financial viability of the entire organization. The DMHC works with each individual RBO because they have separate CAPs and different reasons for being non-compliant.

Ms. Rouillard said if the MSO is continually having problems with claims timeliness or claims to cash, for example, it raises a question about whether they are competent to be able to do that work.

Ms. Yamanaka stated, for claim's timeliness, it is all one system so one group could be compliant and another group may not be compliant depending on the issue. For example, if a new system is implemented, it could be across the board, versus if the MSO is having problems with just one group, it may not affect the others. The DMHC tries to find the root cause.

Mr. Grgurina asked for an explanation of the difference between the monitor closely list versus a corrective action plan.

Ms. Yamanaka stated if a group is non-compliant with some of the metrics it is put on a CAP. The monitor closely list looks at trends over time. When examiners are reviewing

the financial statements, they look for concerns like continuing net losses or a substantial increase or decrease in enrollment.

9) Health Plan Quarterly Update

Ms. Dutt presented the health plan quarterly update for the fourth quarter of 2018.

- There were 80 full-service health plans and a total of 127 Knox-Keene licensed health plans, which is six more compared to the same period last year. For the six new plans, five were full-service plans, which included three Medicare Advantage Plans, one restricted Medi-Cal and one restricted Medicare. The Department also licensed a behavioral health plan.
- As of December 31, 2018, full-service plans licensed by the Department serve 26.2 million lives, an increase of approximately 80,000 compared to last year.
- There were 29 full-service plans with 7.7 million lives on the closely-monitored list compared to 16 in 2017. Of the 29 full-service plans, 12 are restricted licensees with almost 1.4 million lives. There were three specialized plans, with an estimated 140,000 lives, on the closely-monitored list.
- More than half of health plans are reporting TNE of over 500 percent. Seven plans are below 130 percent TNE. Entities below 130 percent of minimum TNE are automatically placed on monthly reporting.
- There were 20 plans on corrective action plans, including nine in progress and 11 pending approval.
- There were 34 completed examinations, 21 in progress and seven planned for fiscal year 2018-19.

Discussion

Mr. Conklin asked if the Department knows how many RBOs will need to be licensed, and if so, will there be a staffing and resource issues moving forward. Ms. Ream stated the Department estimated two-thirds of the ACO arrangements would need to apply for a license or an exemption. However, Ms. Ream indicated it is difficult to know without seeing the arrangements and contracts whether it would be a license or exemption.

Mr. Conklin said he could foresee a bottleneck if there are RBOs that need a license, which could then impact resources that process the licenses. Ms. Ream replied the Department's goal and intention is not to disrupt the market and the arrangements. The Department will shift resources around to address any bottleneck issues that may arise.

Dr. Rideout stated IHA has ACO performance information on 87 different plan and provider contracts that cover ACOs. Mr. Conklin asked how many lives are covered through all the ACOs. Dr. Rideout estimated it to be more than 50 percent of the market.

Mr. Barcelona asked why the plans on a CAP are not listed in the same way as the groups with a CAP. Ms. Dutt stated those CAPs are part of the routine examination and

are confidential. Mr. Barcelona pointed out if an RBO is trying to contract with a plan, it would be beneficial to see if it is on a CAP. Mr. Barcelona asked the Department to revisit that policy.

10) Public Comment on Matters not on the Agenda

Mr. Grgurina asked for public comment on items not on the agenda. There was no public comment.

11) Agenda Items for Future Meetings

Mr. Grgurina asked for agenda items for future meetings, and noted he would appreciate a review of Atlas 3.0. Mr. Durr indicated he would like to discuss the risk regulation process, specifically what the Department is finding in the contract arrangements and the potential administrative burden it may create.

12) Closing Remarks/Next Steps

The meeting was adjourned at 12:01 p.m.